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SENATE REPUBLICAN POLICY COMMITTEE

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The Advantage of Medicare Advantage

Executive Summary

- Seniors have increasingly turned to Medicare Advantage plans because they offer a better value and a higher quality of care than traditional fee-for-service Medicare. Their surging popularity demonstrates that seniors prefer the level of service and care offered by private providers in Medicare as opposed to a one-size-fits-all government-run health plan.

- Enrollment in Medicare Advantage is now at an all-time high. Currently, 8.3 million beneficiaries are enrolled in these plans, representing about 19 percent of all Medicare beneficiaries. Medicare Advantage beneficiaries receive on average $86 per month, or more than $1,000 a year, in additional benefits above traditional fee-for-service Medicare.

- In contrast to traditional fee-for-service Medicare, Medicare Advantage plans utilize coordinated care management, an innovation that is central to reducing long-term health spending. By using this approach, Medicare Advantage plans have shown that they can deliver care below the cost of traditional fee-for-service and with high levels of patient satisfaction.

- In August, the House of Representatives passed H.R. 3162, the Children's Health and Medicare Protection Act of 2007 (the CHAMP Act), which called for cuts to Medicare Advantage totaling $157 billion over ten years. Enacting cuts similar to those in the CHAMP Act will have a devastating impact on Medicare Advantage providers and seniors enrolled in these plans, particularly those in rural areas.

- Critics who argue that the government overpays private providers that offer services under Medicare Advantage misunderstand the way that Medicare Advantage works. Any savings under Medicare Advantage accrue to the seniors or to the government, not to providers.

- CBO reported that if significant cuts to Medicare Advantage plans were enacted "it is clear that plans would be forced to increase cost sharing… [and] would probably also need to modify their benefit packages and increase premiums as well."

Introduction

As the national debate over health care reform begins to focus on whether the government should replace private insurers as the primary provider of health care services, a similar debate is occurring in Congress over the role of private plans in Medicare. Known as "Medicare Advantage" plans, seniors have increasingly turned to these private plans because they offer a better value and a higher quality of care than traditional fee-for-service Medicare.[1] Their surging popularity demonstrates that seniors prefer the level of service and care offered by private providers in Medicare as opposed to a one-size-fits-all government-run health plan.

Enrollment in Medicare Advantage is now at an all-time high. Currently, 8.3 million beneficiaries are enrolled in these plans, representing about 19 percent of all Medicare beneficiaries.[2] Medicare Advantage beneficiaries receive on average $86 per month, or more than $1,000 a year, in additional benefits above traditional fee-for-service Medicare.[3] The additional benefits often include lower costs in the form of reduced cost sharing for medical services and prescription drugs, additional services like dental care (which are not provided by traditional Medicare), and care coordination and disease management services to promote better health for senior beneficiaries.

In August, the House of Representatives passed H.R. 3162, the Children's Health and Medicare Protection Act of 2007 (the CHAMP Act), which called for cuts to Medicare Advantage totaling $157 billion over ten years.[4] The Senate is expected to consider cuts to Medicare Advantage before the end of the year in order to offset postponing scheduled payment reductions for physicians who provide care under Medicare. Enacting cuts similar to those in the CHAMP Act will have a devastating impact on Medicare Advantage providers and seniors enrolled in these plans, particularly those in rural areas. These seniors would see their benefits cut or could even see their plan pull out of Medicare completely.

Recently, Medicare Advantage plans have been criticized for their cost when compared to traditional fee-for-service Medicare. However, this criticism fails to take into account the breadth of additional services and benefits provided to seniors by Medicare Advantage plans. These criticisms also oversimplify a complex payment formula. While Medicare as a whole poses long term fiscal challenges, the health management practices implemented by Medicare Advantage plans offer one of the best ways to help control long-term costs. In fact, payment increases for Medicare Advantage plans for 2007 were less than for expenditure growth in traditional fee-for-service Medicare.[5] Rather than backing away from policies that are working

[1] The Medicare Advantage program offers several different types of plans, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS), and special needs plans (SNPs).
[2] Congressional Budget Office, Statement of Director Peter Orszag before the Subcommittee on Health, Committee on Ways and Means, "The Medicare Advantage Program: Trends and Options," March 21, 2007.
[3] Centers for Medicare and Medicaid Services, "Medicare Advantage Overview," July 10, 2007.
[4] The CHAMP Act also included legislation reauthorizing the State Children's Health Insurance Program (SCHIP). The provisions regarding Medicare Advantage were dropped in conference committee, but may be revived when the Senate passes legislation to delay scheduled payment reductions to doctors who provide care under Medicare.
[5] CMS, Press Release, "Medicare Advantage Plans Provide Lower Costs and Substantial Savings," April 3, 2006.

to provide seniors more benefits at lower out-of-pocket costs, members of Congress should embrace the successes of the Medicare Advantage program.

Promoting High-Quality Health Care

In contrast to traditional fee-for-service Medicare, Medicare Advantage plans utilize coordinated care management, an innovation that is central to reducing long-term health spending. As opposed to traditional Medicare, which reimburses physicians per procedure, Medicare Advantage plans are reimbursed a pre-determined amount per beneficiary (known as a "capitated" payment).[6] These plans therefore have an incentive to ensure that beneficiaries are provided care in the most clinically appropriate manner, including investments in preventive care and care management to prevent unnecessary and costly hospitalizations. This is one of the most promising ways to control long-term spending trends without restricting access to care.

By using these approaches, Medicare Advantage plans have shown that they can deliver care below the cost of traditional fee-for-service and with high levels of patient satisfaction.[7] In its most recent report to Congress, the Medicare Payment Advisory Commission (MedPAC) wrote that, "Private plans may have greater flexibility in developing innovative approaches to care, and these plans can more readily use tools such as negotiated prices, provider networks, care coordination and other health care management techniques to improve the efficiency and quality of health care services."[8]

Providing Additional Benefits for Seniors

By law, Medicare Advantage plans must provide coverage at least equivalent to the coverage provided under traditional Medicare. In practice, Medicare Advantage plans offer significantly more benefits than fee-for-service Medicare. On average, beneficiaries enrolled in Medicare Advantage plans will save $86 more per month compared with what they would have received in traditional Medicare.[9] Beneficiaries with fair or poor health often benefit the most

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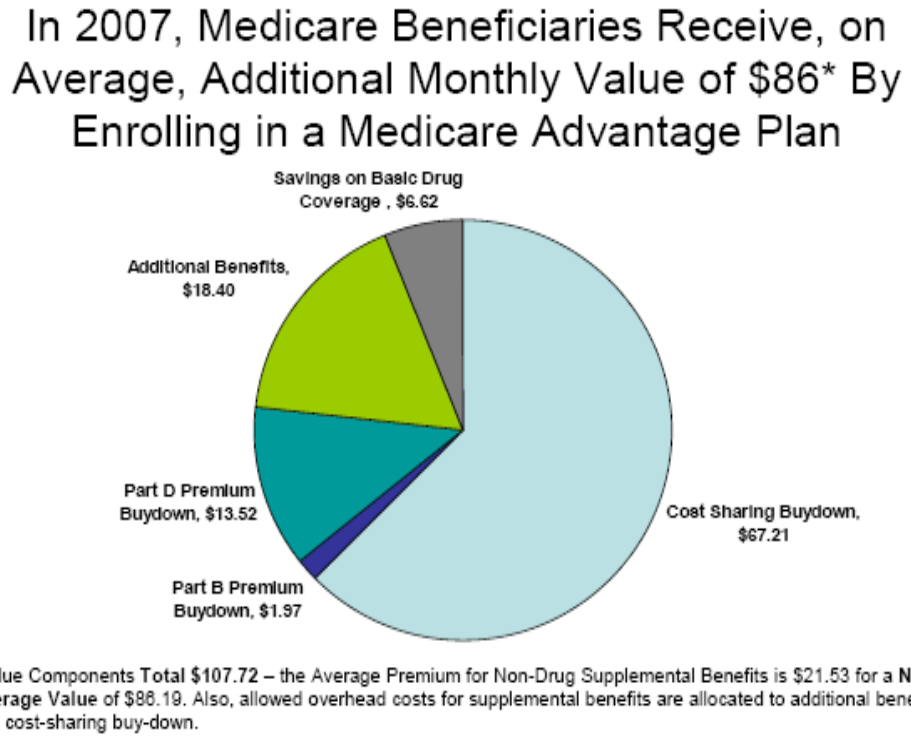
[6] This payment methodology can help stabilize budget costs and allow the government to better predict how much will be spent each year on Medicare. It also shifts the risk of any cost increase on to private providers rather than the government, since any increased costs must be absorbed by the health plans.

[7] For example, in 2006, HMO plans were able to provide services equivalent to traditional fee-for-service Medicare for 97 percent of Medicare fee-for-service expenditure levels. Statement by Mark Miller, Executive Director of the Medicare Payment Advisory Commission, before the Committee on the Budget, U.S. House of Representatives, "The Medicare Advantage Program and MedPAC Recommendations," June 28, 2007.

[8] Statement by Mark Miller, Executive Director of the Medicare Payment Advisory Commission, before the Committee on the Budget, U.S. House of Representatives, "The Medicare Advantage Program and MedPAC Recommendations," June 28, 2007. Similarly, Peter Orszag, Director of the Congressional Budget Office, reported that a "key feature of many HMO and PPO plans under Medicare Advantage is wellness programs and case management services; those services are intended to promote better coordination and more effective use of health care." Congressional Budget Office, Statement of Director Peter Orszag before the Subcommittee on Health, Committee on Ways and Means, "The Medicare Advantage Program: Trends and Options," March 21, 2007.

[9] Centers for Medicare and Medicaid Services, "Medicare Advantage Overview," July 10, 2007. This represents an estimated $6.8 billion in additional benefits. Adam Atherly, Ph.D. and Kenneth Thorpe, Ph.D., "The Impact of Reductions in Medicare Advantage Funding on Beneficiaries," April 2007.

since the additional benefits and lower cost- sharing provided by Medicare Advantage plans disproportionately benefit those who need more care.



Centers for Medicare and Medicaid Services (CMS), Medicare Advantage in 2007, April 20, 2007

Below are just a few examples of additional benefits provided to seniors enrolled in Medicare Advantage plans:[10]

- Ninety-six percent of Medicare Advantage plans offer coverage for routine physical examinations and 77 percent cover eye exams.[11] Traditional Medicare does not offer annual physicals or vision coverage;
- In 2006, approximately 5.7 million beneficiaries received Medicare prescription drug coverage through their Medicare Advantage plan.[12] Furthermore, 70 percent of Medicare beneficiaries can choose a Medicare Advantage plan that does not require the beneficiary to pay a premium for prescription drug coverage;[13]
- Nearly every senior can select a Medicare Advantage plan that provides protection against catastrophic health care expenses by capping annual out-of-pocket costs.

[10] Medicare Advantage plans can offer many additional benefits, such as prescription drug plans and catastrophic coverage, at lower costs than traditional Medicare plans due to their coordinated care infrastructure.
[11] Centers for Medicare and Medicaid Services, "Medicare Advantage in 2007," updated April 20, 2007.
[12] Centers for Medicare and Medicaid Services, Capitol Hill Notifications, April 3, 2006.
[13] Centers for Medicare and Medicaid Services, Press Release, "Medicare Advantage Plans Provide Lower Costs and Substantial Savings," April 3, 2006.

Medicare by itself does not provide coverage for catastrophic illness or limit out-of-pocket costs;[14] and

- More than 90 percent of Medicare Advantage plans provide coverage for additional acute care days and stays in skilled nursing facilities.[15] Seniors using traditional Medicare may face significant costs for these benefits.

The added benefits and the reduced cost of seeking care are important to seniors' health. For example, Medicare Advantage beneficiaries are more likely to get pneumoccocal and influenza immunizations, mammographies, colorectal screenings, and prostate screenings than beneficiaries in fee-for-service Medicare.[16] Seventeen percent of beneficiaries in traditional Medicare without supplemental coverage report delaying care due to cost as compared to only 6 percent of those in Medicare Advantage programs.[17] Additionally, Medicare Advantage plans have an incentive to provide coordinated care and other care management services to assist seniors with chronic diseases. A number of plans now specialize in such care coordination, which can help reduce the financial cost of covering these individuals as compared to traditional fee-for-service.

An Important Option for Rural Beneficiaries

Before 1998, the payment formula for Medicare Advantage plans in effect limited providers largely to urban and suburban populations. This limitation led Congress to make changes to encourage more plan participation in rural areas.[18] Congress took additional steps in the Medicare Modernization Act (MMA)[19] to encourage more plans and beneficiaries to participate in the program. Currently, every senior has access to a Medicare Advantage coverage option, and seniors are increasingly taking advantage of these choices. Between 2003-2007,

[14] Medigap supplemental insurance can be purchased to provide protection against catastrophic illness, but it can be expensive for those on a fixed income. For example, the national average cost of a Medigap policy for a 65-year-old female ranged from $1,159 to $3,443. *Senior Journal*, "Vast Differences in Medigap Insurance Rates for Same Benefits," August 29, 2005. Conversely, many Medicare Advantage plans offer this benefit for no additional cost.
[15] Centers for Medicare and Medicaid Services, "Medicare Advantage Overview," July 10, 2007.
[16] Centers for Medicare and Medicaid Services, "Overview of the Medicare Advantage Program," May 2007.
[17] Centers for Medicare and Medicaid Services, "Medicare Advantage in 2007," updated April 20, 2007.
[18] Congress expanded the availability of plans beyond urban areas by creating a national payment floor in the Balanced Budget Act and increased the rural floor again in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CBO reported that the reason it is more difficult and costly for Medicare Advantage plans to participate in rural areas as compared to urban, densely populated areas is that there are fewer providers in rural areas. This diminishes plans' leverage in negotiations with providers. CBO also noted that it is easier for private plans to achieve cost savings in urban areas where costly services are used more frequently and can be managed through intervention. Congressional Budget Office, Statement of Director Peter Orszag before the Subcommittee on Health, Committee on Ways and Means, "The Medicare Advantage Program: Trends and Options," March 21, 2007. This is why Congress established payment floors for these rural areas (and low cost urban counties). These floors represent an important policy decision by Congress, which account in large part for the disparity between fee-for-service and Medicare Advantage costs. Without these floors, Medicare Advantage plans would be unsustainable in these areas and beneficiaries would be restricted to traditional fee-for-service with limited access to physicians and coordinated care.
[19] P.L. 108-173.

more than 600,000 beneficiaries in rural areas joined the Medicare Advantage program − a 426-percent increase.[20]

A recent study to determine the impact of cuts to Medicare Advantage predicted that the cuts would be felt most in rural areas. Even though Congress acted to increase payments to rural areas to promote Medicare Advantage coverage, the report found that "[h]ealth plan options in rural areas… would face the largest reductions."[21] Thus, cuts to Medicare Advantage would result in a direct reversal of congressional policy to expand access to these plans for rural seniors.

Seniors Enrolled in Medicare Advantage Plans are Disproportionately Lower-Income and Low-Income Minorities who Fall through the Safety Net

The additional benefits provided by Medicare Advantage are particularly important because a higher proportion of these beneficiaries are lower-income. Congressional Budget Office (CBO) Director Peter Orszag noted that the additional benefits and premium rebates offered by Medicare Advantage "may be particularly attractive to people with relatively low income."[22] Indeed, a 2005 report found that 50 percent of Medicare Advantage enrollees had incomes of less than $20,000.[23]

Furthermore, minority beneficiaries are more likely to enroll in Medicare Advantage plans. While only 33 percent of eligible white seniors who do not have Medicaid or employer-based coverage are enrolled in Medicare Advantage plans, 40 percent of Medicare-eligible African-Americans, and 53 percent of Medicare-eligible Hispanics without Medicaid or employer-based coverage are enrolled in Medicare Advantage plans.[24] This is a primary reason why the NAACP and League of United Latin American Citizens (LULAC) have expressed concerns regarding cuts to Medicare Advantage.[25]

Low-income seniors are most likely to forgo supplemental coverage if they lose their Medicare Advantage plan. While an estimated 39 percent of Medicare Advantage enrollees would go without supplemental coverage if they lose their Medicare Advantage plans, 59 percent

[20] Testimony of Leslie Norwalk, Acting Administrator, Center for Medicare and Medicaid Services, before the House Ways and Means Subcommittee on Health on the Medicare Advantage Program, March 21, 2007.
[21] Adam Atherly, Ph.D. and Kenneth Thorpe, Ph.D., "The Impact of Reductions in Medicare Advantage Funding on Beneficiaries," April 2007. Similarly, CBO determined that cuts similar to those in the CHAMP Act "would lead to a reduction in the number of plans offered in most areas of the country. *Some areas would lose all or nearly all of their plans*…" (emphasis added). Congressional Budget Office letter to the Honorable Jim McCrery, Ranking Republican, Committee on Ways and Means, October 10, 2007.
[22] Congressional Budget Office, Statement of Director Peter Orszag before the Subcommittee on Health, Committee on Ways and Means, "The Medicare Advantage Program: Trends and Options," March 21, 2007.
[23] Adam Atherly, Ph.D. and Kenneth Thorpe, Ph.D., "Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries," September 20, 2005.
[24] Adam Atherly, Ph.D. and Kenneth Thorpe, Ph.D., "The Impact of Reductions in Medicare Advantage Funding on Beneficiaries," April 2007.
[25] *Medical News Today*, "Minority Groups Oppose Proposed Reductions in Funds for Medicare Advantage Plans," March 20, 2007.

of African-American beneficiaries would go without supplemental coverage.[26] Moreover, only 18 percent of enrollees with incomes below $10,000 a year would purchase supplemental insurance, as compared to 57 percent of those with income over $30,000. According to a comprehensive study, when Medicare + Choice plans (the predecessor to Medicare Advantage) responded to payment cuts by reducing beneficiaries, "those who did not keep their supplemental coverage were disproportionately least educated and had lower incomes."[27]

Congress Should Not Repeat the Mistakes of the Past

If one consideration should influence policymakers considering changes to Medicare Advantage payments, it should be to avoid the mistakes of the past. When earlier Congresses cut payments to private plans in Medicare, plans were forced to respond by disenrolling seniors, creating an angry outcry by these constituents. An article in the *New York Times* from 1998 reported that cuts to Medicare in the Balanced Budget Act of 1997 did "exactly what critics feared: building expectations among the elderly, then dashing them, leaving the subscribers angry and confused."[28] Because the cost of delivering services in rural areas exceeded the cost of providing care, "the more beneficiaries [a provider] enrolled, the more money it lost."[29] When the Clinton Administration refused to allow increases in cost-sharing to allow these private plans to remain in the Medicare program, "insurers in at least 19 states announced they would terminate coverage of some Medicare beneficiaries…."[30]

A lengthy independent study of the lessons from prior payment reductions to private plans in Medicare found that cuts to reimbursement rates helped create a "downward spiral" that left beneficiaries and providers feeling "burned."[31] In fact, from 2000-2003, enrollment in private plans in Medicare declined by 1.7 million beneficiaries.[32]

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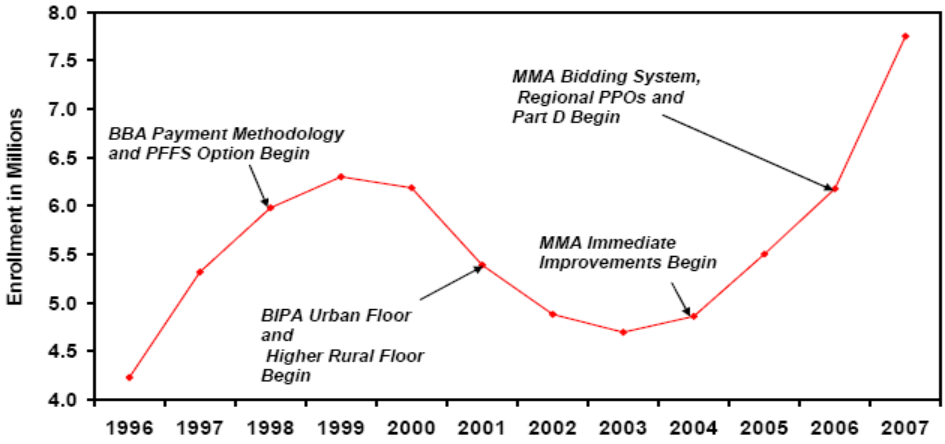
[26] Adam Atherly, Ph.D. and Kenneth Thorpe, Ph.D., "Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries," September 20, 2005.
[27] Mathematica Policy Research, "Monitoring Medicare + Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage," August 2004.
[28] *New York Times*, "End of H.M.O. for the Elderly Brings Dismay in Rural Ohio," July 31, 1998.
[29] *New York Times*, "End of H.M.O. for the Elderly Brings Dismay in Rural Ohio," July 31, 1998.
[30] *Omaha World Herald*, "HMO Official Says Move Won't Help Medicare Beneficiaries," October 11, 1998.
[31] Mathematica Policy Research, "Monitoring Medicare + Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage," August 2004. Additionally, the report warned that the government needs to be seen as "a reliable business partner" for private plans to succeed under Medicare. Notably for the current situation in Congress, the report said, "If there is change in leadership of the executive or legislative branch, the way new leaders interact with industry could affect the way plans react to the MMA."
[32] Adam Atherly, Ph.D. and Kenneth Thorpe, Ph.D., "Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries," September 20, 2005.

Medicare Advantage Enrollment History and Major Payment Changes*



*The Medicare Advantage program began in 2004. Enrollment for 1996-1997 reflects risk plan enrollment, 1998 – 2003 reflects Medicare+Choice enrollment.

Source: Centers for Medicare & Medicaid Services, Analysis of State-County-Plan Enrollment Reports, 1999-2005, OACT 2006 (MMR), 2007 MIIR
Medicare Advantage options exclude HCPPs, Cost Plans and Demos (except PPO Demonstration)

CMS, Medicare Advantage Overview, July 10, 2007

If Congress acts hastily to cut payments, similar results are a virtual certainty.[33] CBO recognized this danger when it reported that cuts to Medicare Advantage "would make the Medicare Advantage program less attractive for health plans and cause some to leave the program, as they did after Congress cut payment rates in the Balanced Budget Act of 1997."[34] Similarly, MedPAC warned that "payment reductions may result in disruptions for beneficiaries and for plans…."[35]

CBO recently confirmed that cuts to Medicare Advantage could cut millions of Medicare Advantage beneficiaries off of their current health plans. CBO analyzed the CHAMP Act, which calls for a $157 billion cut to Medicare Advantage, and found that 7 million fewer beneficiaries would be enrolled in Medicare Advantage in 2012 than currently projected.[36] This represents a reduction of 2.7 million beneficiaries below current enrollment levels.[37] Thus, the estimated

[33] Because there are more beneficiaries in Medicare Advantage now than when earlier cuts to Medicare + Choice were implemented, impacts to beneficiaries are potentially greater. The Atherly and Thorpe study found that reducing payments to Medicare Advantage, as suggested by the MedPAC report, would result in impacts similar to or worse than cuts following the 1997 Balanced Budget Act, after which 2 million people dropped Medicare + Choice coverage. Adam Atherly, Ph.D. and Kenneth Thorpe, Ph.D., "The Impact of Reductions in Medicare Advantage Funding on Beneficiaries," April 2007.

[34] Congressional Budget Office, Statement of Director Peter Orszag before the Subcommittee on Health, Committee on Ways and Means, "The Medicare Advantage Program: Trends and Options," March 21, 2007.

[35] Medicare Advantage Recommendations from MedPAC's June 2005 report to Congress.

[36] Congressional Budget Office letter to the Honorable Jim McCrery, Ranking Republican, Committee on Ways and Means, October 10, 2007.

[37] Congressional Budget Office letter to the Honorable Jim McCrery, Ranking Republican, Committee on Ways and Means, October 10, 2007.

savings from cuts to Medicare Advantage are largely a result of seniors losing their current plan coverage, rather than reducing the cost of that coverage.

A Fair Comparison of Medicare Advantage Plan Payments to Fee-for-Service

Lost in press reports about the MedPAC report and its conclusion that certain Medicare Advantage plans may be overpaid is the important finding that these plans on average provide the Medicare benefit for less than traditional fee-for-service Medicare. The report found that "on average in 2006, *HMO plans were able to provide the traditional Medicare benefit for 97 percent of Medicare FFS expenditure levels.*"[38] (emphasis added).

Additionally, some of the current cost disparity is in part a result of budget neutrality rules enacted to help Medicare Advantage plans transition to a risk-adjustment payment methodology. Under the current payment methodology, these adjustments are automatically being phased out and will be eliminated by 2011, even if Congress does nothing. In fact, during the last two years the rate of growth in Medicare fee-for-service costs has exceeded the actual growth rate of Medicare Advantage payments when adjusted for the risk profiles of enrollees. While fee-for-service rates for 2008 will grow by 5.7 percent,[39] actual increases in Medicare Advantage plan payments are estimated to average just 2.4 percent when accounting for the phase-out of the budget neutrality adjustment and other adjustments impacting actual payment rates.[40] For 2007, the disparity was even larger, with an estimated fee-for-service growth rate of 7.1[41] percent compared to a 1.1 percent growth rate for Medicare Advantage, assuming no change in plan risk scores.[42]

Additionally, MedPAC's estimate that payments to Medicare Advantage plans are on average 12-percent higher than traditional Medicare fee-for-service oversimplifies a complex payment formula. The MedPAC estimate does not account for administrative costs for delivering services under traditional Medicare. More significantly, the MedPAC analysis excludes the cost of indirect medical education payments to fee-for-service Medicare, but includes those same costs when assessing Medicare Advantage. After accounting for these issues and the additional benefits provided by Medicare Advantage plans, former CMS acting Administrator Leslie Norwalk testified that, "In large part, any remaining differential reflects

[38] Overall, Medicare Advantage plans provide the Medicare benefit for 99 percent of what Medicare FFS costs. Statement by Mark Miller, Executive Director of the Medicare Payment Advisory Commission, before the Committee on the Budget, U.S. House of Representatives, "The Medicare Advantage Program and MedPAC Recommendations," June 28, 2007.
[39] CMS, Announcement of Calendar Year (CY) 2008 Medicare Advantage Capitation Rates and Payment Policies, April 2, 2007.
[40] Medicare Advantage News, "Actual MA Pay Hikes Averages 2.4% for '08," April 19, 2007, available at: http://www.network-health.org/pdf/medicare_advantage_news_20070417.pdf.
[41] CMS, Announcement of Calendar Year (CY) 2007 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, April 3, 2006.
[42] CMS, "Capitation Rates and Medicare Advantage and Part D Payment Policies Fact Sheet," http://www.allhealth.org/BriefingMaterials/CMSfactsheet2007-249.pdf.

Congressional decisions to increase the benchmark above FFS in certain areas, such as rural areas, to ensure access to private plans across the country."[43]

Additional Payments Go to Beneficiaries and the Government, Not to Providers

Critics who argue that the government overpays private providers that offer services under Medicare Advantage misunderstand the way that Medicare Advantage works. If anything, Medicare Advantage overpays beneficiaries (i.e. seniors). To participate in Medicare Advantage, a private provider must submit a competitive bid stating the price at which it is willing to provide services. That bid is measured against a statutorily determined benchmark which establishes the maximum price the government would pay to a provider for these services. In most cases, the bids from private providers are below the rate that the government offers to pay.[44]

It is important to understand what happens when a plan bids below the benchmark (which happens in the vast majority of cases). Critically, the difference between the provider's bid and the amount the government sets as a benchmark does not go to the provider. Instead, by law, 75 percent of the amount by which the benchmark exceeds the bid must be returned to beneficiaries in the form of additional benefits or premium rebates, and the other 25 percent is returned to the government. In 2007, Medicare Advantage plans are expected to provide an estimated $6.8 billion in supplemental benefits to beneficiaries and return more than $2 billion to the Treasury.[45] Thus, any alleged overpayments are returned to the beneficiaries or the government, not to the plans.

At its core, critics are therefore asserting that seniors are overpaid by Medicare Advantage and receive too many benefits.[46] MedPAC acknowledged this reality even when advocating a cut in payments. The report stated that reducing benchmark payments "would result in fewer plan offerings and less generous benefits."[47] CBO confirmed that "it is clear that plans would be forced to increase cost sharing… [and] would probably also need to modify their benefit packages and increase premiums as well" if cuts were enacted.[48] Reduced benefits combined with increased premiums and cost-sharing would certainly provoke a negative response from seniors who enjoy these plans.

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[43] Testimony of Leslie Norwalk, Acting Administrator Centers for Medicare and Medicaid Services, before the House Ways and Means Subcommittee on Health on the Medicare Advantage Program, March 21, 2007.
[44] Congressional Budget Office, "Medicare Advantage: Private Health Plans in Medicare," June 28, 2007.
[45] Adam Atherly, Ph.D. and Kenneth Thorpe, Ph.D., "The Impact of Reductions in Medicare Advantage Funding on Beneficiaries," April 2007.
[46] If so, the simple solution would be to change the formula used to redistribute funds when plans bid below the benchmark. For example, the formula could require that 100 percent of the amount by which the benchmark exceeds the bid be returned to the Treasury. Presumably, a change such as this would make too obvious the fact that cutting Medicare Advantage would directly cut benefits to seniors.
[47] Statement by Mark Miller, Executive Director of the Medicare Payment Advisory Commission, before the Committee on the Budget, U.S. House of Representatives, "The Medicare Advantage Program and MedPAC Recommendations," June 28, 2007.
[48] Congressional Budget Office letter to the Honorable Jim McCrery, Ranking Republican, Committee on Ways and Means, October 10, 2007.

Conclusion

Any payment reduction to Medicare Advantage, such as the one proposed in the CHAMP Act, will directly result in a cut in benefits to seniors. That is in part why CBO cautioned that policymakers considering reducing payments to Medicare Advantage plans "need to weigh the cost savings against any benefits that plans provide in managing utilization, the effect on health care costs overall, and the impact on beneficiaries."[49] Medicare Advantage plans are overwhelmingly popular with beneficiaries, and they offer a way to control long-term health costs that threaten Medicare. Moreover, seniors have shown that they prefer the benefits and services offered by private providers rather than a one-size-fits-all government-run health plan. Congress should think carefully before it takes any action that would jeopardize seniors' access to plans on which they have come to trust and depend.

[49] Congressional Budget Office, Statement of Director Peter Orszag before the Subcommittee on Health, Committee on Ways and Means, "The Medicare Advantage Program: Trends and Options," March 21, 2007.